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Public Opinion Regarding AIDS Policy: Fear of Contagion and Attitude Toward Homosexual Relationships

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ABSTRACT

This study examines public attitudes toward selected AIDS policies and tests the extent to which fear of contracting AIDS on the one hand, and attitude toward homosexuality on the other hand, influence opinions regarding the screening of potentially infected persons and the isolation of those already identified as infected. The data for this study are drawn from a 1989 survey of a representative sample of the adult residents of Edmonton, Alberta, Canada (n=443). We find that fear of contracting AIDS and attitude toward homosexual relationships independently predict support for AIDS screening and isolation policies.

Keywords: AIDS, social policy, screening, isolation, fear of contracting AIDS, attitudes toward homosexuality

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INTRODUCTION

People have various opinions regarding the appropriate public response to AIDS. The fatal nature of AIDS may motivate people to favor policies that would protect them from exposure to HIV infected persons. In other words, fear of contracting AIDS may cause people to support policies directed at the screening of potentially infected persons and the isolation of those already identified as infected. Alternatively, it has been argued that social reactions to AIDS are not based solely on fear of contagion. Rather, it has been suggested that, because of the early association of AIDS with homosexuality, fear of contagion vis-a-vis the disease is confounded with feelings of contamination associated with a stigmatized social group [1-4].

In contrast to those who suggest that fear of contagion and negative attitudes toward homosexuals are facets of a single underlying attitude, others have argued that each of these variables exerts a unique influence on attitudes towards persons with AIDS [5-7]. Nevertheless, the relative effects of fear of contagion and attitudes toward homosexuals on support for screening and isolation policies has not been extensively examined and remains unclear. Bouton, et al., in a sample of

college students, found that fear of AIDS and homophobia each had substantial effects on attitudes toward public protection measures. Path analysis further revealed that the effects of these variables, while similar in magnitude, were nevertheless largely independent of each other [6]. On the other hand, Pryor et al. in examining attitudes toward nonhomosexual persons with AIDS, found that fear of contagion had greater predictability than attitude toward homosexuality in some situations, while in others, negative feelings toward homosexuals was the primary predictor [7].

The purposes of this study were to examine public attitudes toward selected AIDS policies, and to test the extent to which fear of contracting AIDS on the one hand, and, on the other hand, attitude toward homosexuality influence opinions regarding AIDS screening and isolation. We hypothesize that each of these factors will make unique contributions to the explanation of attitudes toward the screening of potentially infected individuals and the isolation of persons with AIDS.

METHOD

In 1989, a representative sample of 443 adult residents of the city of Edmonton, Alberta, Canada were asked questions about AIDS policy issues in face-to-face interviews. Those interviews were part of the Edmonton Area Survey, conducted annually since 1976. The following questions were asked:

A. Attitudes towards selected AIDS policies: How much do you agree or disagree with these statements? (1=strongly disagree; 7=strongly agree).

1. (Funding) More government funds should be allocated to AIDS research, treatment and education.
2. (Choice Regarding Care of AIDS Patients) Health care professionals should have the choice of whether or not to care for AIDS patients.
3. (Confidentiality of AIDS Test Results) When someone goes to the doctor to be tested for AIDS, the results should be confidential.
4. (Screening and Isolation)
   a. To protect the public, health care workers should be screened for AIDS.
   b. When they are admitted, all hospital patients should be screened for AIDS.
   c. Employers should have the right to ask an employee to be tested for AIDS.
   d. Children with AIDS should be prevented from attending public school.
   e. Persons with AIDS should be quarantined so they are not in contact with the general public.

B. Fear of Getting AIDS: How much do you agree or disagree with these statements? (1=strongly disagree; 7=strongly agree).

1. If one of my family members was a nurse, I would be concerned about his or her taking care of AIDS patients.

2. I am afraid that I or someone close to me will get AIDS.
3. Medical science does not know enough about AIDS to provide us with sufficient information on how to protect ourselves from it.

C. Attitude Toward Homosexual Relationships: How strongly do you approve or disapprove of two men or two women openly living together in a homosexual relationship? (1=strongly disapprove; 7=strongly approve).

D. Religiosity:

1. In regards to your religious preference, would you call yourself a strong or not very strong (religious preference)? (strong=1; not very strong=0)
2. Attend Church (one or more times in past four weeks=1; no times in past four weeks=0)

E. Demographic Variables:

1. Sex (female=1; male=0)
2. Age
3. Marital Status (married/common law=1; all others=0)
4. Employed in Health and Social Service Industries (yes=1; no=0)
5. Education (in years)
6. Rent/Own (rent=1; own=0)
7. Household Income
8. Have you ever personally known anyone who had AIDS? (yes=1, no=0)

The methods of analysis include the following. The percent distributions of responses to the AIDS policy items were tabulated and the correlation matrix of these items calculated. Next, the attitudes towards AIDS policies were treated as dependent variables in regression analyses using the fear of getting AIDS variables, attitude toward homosexual relationships, religiosity, and demographic variables as predictors. In these regression analyses, the fear variables were first entered alone in a block. The attitude toward homosexual relationships variable was also entered alone. Next both the fear and attitude toward homosexual relationships variables were entered together. The religiosity variables were then added to the regression and finally, the demographic variables were entered. The change in R^2 from step-to-step was examined for significance using an F test. The unstandardized partial regression coefficients were compared from step-to-step to see if adding variables reduced or eliminated their initial apparent explanatory effect.

FINDINGS

Very few of the respondents to the survey (6.1%) have personally known someone who had AIDS. With respect to attitude towards homosexual relationships, 49.1% strongly disapprove (7 on the 7-point scale) of two men or two women openly living in a homosexual relationship, 64.0% disapprove to at least some degree (5,6 or 7 on the 7-point scale), 22.6% choose 4 on a

7-point scale (neither approve nor disapprove) suggesting a live and let live attitude, and 13.5% approve.

Table 1 shows that most respondents (83.7%) approve of spending more government funds on AIDS research, treatment and education. Opinion is divided regarding the right of health professionals to choose whether or not to care for AIDS patients with 47.6% agreeing and 38.1% disagreeing. Most (81.8%) agree that the results of AIDS tests should be confidential. Most (80.4%) agree that health care workers should be screened for AIDS while 67.4% agree that hospital patients should be routinely screened. Nevertheless, only 37.2% agree that employers should have the right to require that an employee be tested. People generally do not endorse the isolation of persons with AIDS with 71.6% opposed to preventing children with AIDS from attending school and 64.9% opposed to quarantining persons with AIDS.

Regarding the fear of getting AIDS, Table 1 shows that while only 25.0% are afraid that they or someone close will get AIDS, 55.2% agree that if a family member was a nurse, they would be concerned about him or her taking care of AIDS patients. Almost half (46.4%) feel that medical science does not know enough about AIDS to provide sufficient information on how to protect ourselves from the disease.

Table 2 shows the correlation of the responses to the AIDS policy items and the fear of getting AIDS items. The screening/isolation subset of items are the most highly intercorrelated; indeed, these 5 items have a reliability alpha

TABLE 1

Percentages of Respondents Agreeing or Disagreeing with Statements About Various AIDS Issues

Issues	Strongly Disagree 1	2	3	4	5	6	Strongly Agree 7
Funding							
- More government funds should be allocated to AIDS research, treatment and education.	3.4	1.8	2.1	9.0	19.1	25.3	39.3
Choice Regarding Care of AIDS Patients							
- Health professionals should have the choice of whether or not to care for AIDS patients	16.4	11.3	10.4	14.3	13.2	16.6	17.8
Confidentiality							
- When someone goes to the doctor to be tested for AIDS, the results should be confidential	5.0	3.4	4.3	5.5	7.5	15.3	59.0
Screening and Isolation							
- To protect the public, health care workers should be screened for AIDS	4.1	2.5	5.1	7.8	14.9	23.4	42.1
- When they are admitted, all hospital patients should be screened for AIDS	7.5	8.9	4.8	11.4	11.6	20.7	35.1
- Employers should have the right to ask an employee to be tested for AIDS	25.3	13.6	6.7	17.2	10.1	11.0	16.1
- Children with AIDS should be prevented from attending public school	40.0	24.8	6.8	12.4	4.9	4.9	6.1
- Persons with AIDS should be quarantined so they are not in contact with the general public	37.7	18.2	9.0	14.5	7.8	4.1	8.7

TABLE 1, continued

Issues	Strongly Disagree 1	2	3	4	5	6	Strongly Agree 7
Concern About Getting AIDS							
- If one of my family members was a nurse, I would be concerned about him or her taking care of AIDS patients	15.5	11.2	6.6	11.6	15.3	19.6	20.3
- I am afraid that I or someone close to me will get AIDS	36.0	18.7	7.5	12.8	9.3	8.2	7.5
- Medical science does not know enough about AIDS to provide us with sufficient information on how to protect ourselves from it	16.1	17.3	10.7	9.3	12.1	16.8	17.5

The number of respondents for each item varies from 427 to 439.

TABLE 2

Correlation Matrix* for Atitudes Toward Various Policy Issues Regarding AIDS

	Issues	2	3	4	5	6	7	8	9	10	11
1.	Funding for AIDS Research	--	.13	--	--	-.14	-.10	-.14	-.11	--	--
2.	Choice Re Caring for AIDS Patient		--	.21	.17	.18	.22	.20	.14	.12	.17
3.	Confidentiality Re AIDS Testing			-.12	-.19	-.23	-.18	-.32	-.19	--	-.10
	Screening/Isolation										
4.	- Screen Health Workers				.44	.30	.20	.28	.21	.16	.25
5.	- Screen Patients					.35	.18	.26	.22	.16	.19
6.	- Screen Employees						.37	.42	.34	.10	.23
7.	- Isolate Children with AIDS							.50	.32	.23	.28
8.	- Isolate Persons with AIDS								.36	.27	.34
	Concern About Getting AIDS										
9.	- Concern for Nurse									.30	.19
10.	- Concern for Self										.27
11.	- Not Enough Known										

All conditions shown are significant at $p < .05$ for one-tailed test. Statistically insignificant correlations are not shown.

of .71. These 5 items were subsequently added together to create a single index which was used as a dependent variable in the regression analyses reported below.

Tables 3 and 4 show the regression analysis of the index of attitudes towards the screening and isolation of AIDS victims regressed on the fear of getting AIDS variables (3 items), attitude toward homosexual relationships, religiosity (2 variables), and demographic variables (8). Table 3 reports the unstandardized regression coefficients while Table 4 reports the standardized regression coefficients. When the fear variables are entered, each has a significant partial correlation coefficient and the overall R^2 is .27. By comparison, the attitude toward gay relationships variable also has a significant effect with an R^2 of .13. When these variables are entered together, the R^2 increases to .33. The change in R^2 is statistically significant indicating that each block of variables makes a unique contribution. Further, the partial regression coefficients remain fairly stable with the attitude towards gay relationships variable changing most. Apparently, the effect of this variable is partly explained away by the fear of getting AIDS variables. The religiosity variables do not have a significant effect. The demographic variables (particularly age, being a health care or social services worker, and having known someone who has AIDS) add significant explanatory power (R^2 increases from .33 to .43). Nevertheless, the effect of the demographic variables has little impact on the partial regression coefficients of the other

variables already in the equation. Those variables affected most are attitude toward homosexual relationships and confidence in medical science suggesting that the explanatory power of these variables could be partially attributed to whether one knows someone with AIDS, whether one is a health or social services worker, or age. In other words, fear, attitude toward homosexual relationships, and demographic characteristics each make unique contributions to the explanation of attitudes towards AIDS screening and isolation. More specifically, those concerned for a family member who is a nurse, or concerned that medical science does not yet have sufficient knowledge to protect us are more likely to favour screening and isolation policies. Those respondents who disapprove of homosexual relationships are also more likely to favour screening and isolation strategies. Older respondents are more likely to endorse screening and isolation but health care and social services workers are less likely to do so. Finally, people who have known a person with AIDS are less likely to favour screening and isolation.

This regression analysis was repeated separately for each of the five items making up the screening/isolation index. The results of these five regression analyses were similar to the results shown in Tables 3 and 4. That is, the fear variables contributed significantly to each of the five screening and isolation items. More specifically, concern for a nurse family member helped explain each of the items while confidence in medical science predicted support for all policies except

TABLE 3

Unstandardized Regression Coefficients for Attitude Toward AIDS Screening and Isolation on Fear, Attitude Toward Homosexual Relationships, Religiosity, and Demographic Variables

	Block IA		Block IB		Block II		Block III		Block IV	
	b	Sig.	b	Sig.	b	Sig.	b	Sig.	b	Sig.
Fear										
Concern for nurse family member	0.98	.00			0.88	.00	0.89	.00	0.89	.00
Fear for self or someone close	0.35	.02			0.36	.01	0.35	.01	0.35	.02
Medical science cannot protect us	0.89	.00			0.78	.00	0.79	.00	0.61	.00
Attitude Toward Homosexuality										
Approval of Homosexuality			-1.28	.00	-0.86	.00	-0.83	.00	-0.69	.00
Religiosity										
Strongly religious							0.58	.34	0.50	.41
Attend church							0.24	.72	-0.10	.88
Demographic Variables										
Female										
Age									0.89	.12
Married									0.09	.00
Health or social services worker									-0.38	.52
Education (years)									-2.62	.01
Rent									-0.01	.88
Household Income									0.00	.99
Know someone with AIDS									-0.07	.09
									-2.88	.01
Constant	10.8	.00	23.1	.00	13.9	.00	13.5	.00	12.1	.00
R^2	.27	.00	.13	.00	.33	.00	.33	.00	.43	.00
R^2 change*					.06	.00	.00	NS	.10	.00

*R^2 change = $R_2^2 - R_1^2$ Significance = $\dfrac{(R_2^2-R_1^2) \;/\; (k_2-k_1)}{(1-R_2^2) \;/\; (N-k_2-1)}$ where k is the number of independent variables in the regression equation and N is the number of respondents.

TABLE 4

Standardized Regression Coefficients for Attitude Toward AIDS Screening and Isolation on Fear, Attitude Toward Homosexual Relationships, Religiosity, and Demographic Variables

	Block IA		Block IB		Block II		Block III		Block IV	
	B	Sig.	B	Sig.	B	Sig.	B	Sig.	B	Sig.
Fear										
Concern for nurse family member	.32	.00			.29	.00	.29	.00	0.29	.00
Fear for self or someone close	.11	.02			.11	.01	.11	.01	0.11	.02
Medical science cannot protect us	.29	.00			.26	.00	.26	.00	0.20	.00
Attitude Toward Homosexuality										
Approval of Homosexuality			-.36	.00	-.24	.00	-.24	.00	-.19	.00
Religiosity										
Strongly religious							.04	.34	.04	.41
Attend church							.02	.72	-.01	.88
Demographic Variables										
Female									.07	.12
Age									.20	.00
Married									-.03	.52
Health or social services worker									-.12	.01
Education (years)									-.01	.88
Rent									.00	.99
Household Income									-.08	.09
Know someone with AIDS									-.11	.01
R^2	.27	.00	.13	.00	.33	.00	.33	.00	.43	.00
R^2 change*					.06	.00	.00	NS	.10	.00

*R^2 change $= R_2^2 - R_1^2$ Significance $= \dfrac{(R_2^2 - R_1^2) / (k_2 - k_1)}{(1 - R_2^2) / (N - k_2 - 1)}$ where k is the number of independent variables in the regression equation and N is the number of respondents.

screening of hospital patients. In contrast, the variable fear of self or someone close getting AIDS contributed to the overall variance of only one screening/isolation item, that of quarantining persons with AIDS. The addition of attitude toward homosexual relationships also helped explain each of the screening and isolation items except opinions regarding screening of health care workers. Demographic variables were significant predictors of all screening/isolation items except the isolation of children with AIDS variable. Specifically, those who had known someone with AIDS were less likely to support screening of health care workers and patients, health care and social services workers were less likely to support screening of health care workers and patients and the quarantining of persons with AIDS, older respondents were more likely to favor screening of employees and quarantining persons with AIDS, and females were more likely to agree with the screening of hospital patients. Finally, the regression analyses were extended to examine the interactive effects of the three fear variables and the attitude toward homosexual relationships (fear X attitude towards homosexual relationships). These interactive terms failed to add significantly to the explained variance.

The same regression analysis was applied to the Funding, Choice Regarding Care of AIDS Patients, and Confidentiality of AIDS Test Results policy items, with the predictor variables explaining only 8%, 7% and 11% of variance respectively. Older persons were less likely to endorse government funding, those

who felt that medical science does not yet have sufficient knowledge to protect us were more likely to agree that health professionals should have a choice of whether or not to care for AIDS patients, and older persons and those most concerned about a family member being a nurse for an AIDS patient were more likely to state that the results of AIDS tests should not be kept confidential. Religiosity and attitude toward homosexual relationships did not contribute significantly to the explanation of opinions regarding these three final policy issues.

DISCUSSION

Although screening measures are not considered by most public health policy makers to be efficacious in protecting the public, our study shows that substantial numbers of people support such measures. Moreover, our analysis suggests that fear of contracting AIDS and attitude toward homosexual relationships independently predict support for AIDS screening and isolation policies.

The fear variable which most consistently exerted a strong unique effect across all screening/isolation items is the concern about a nurse family member caring for AIDS patients. In fact, concern for a nurse family member had the strongest effect among the various predictor variables. Indeed, knowing someone with AIDS or being a health or social services worker did not explain away this relationship. This suggests a perception among the public and health care providers alike that nurses are at increased risk of contracting AIDS. Of

considerable interest is the extent of this concern as reflected in respondents' high level of support for the screening of health care workers, in comparison to support for screening of employees in general. That health care workers are perceived to be at higher risk is also evident when comparing the two measures of personal vulnerability. While only about one-quarter of the sample are afraid that they or someone close to them will get AIDS, over half of the respondents would be concerned if a nurse family member cared for persons with AIDS. Moreover, over two-thirds of the sample favored the screening of hospital patients, possibly to protect health care providers from inadvertent exposure. Although many studies have addressed health care workers' fears of getting AIDS, public opinion of health care workers' risk has been little explored. An Alberta survey in 1988 found that 41% of respondents felt that because of AIDS a career in the health professions can be too risky [8]. Similarly, Pringle et al. found that over half of spouses/partners of homecare nurses were concerned that nurses caring for persons with AIDS may create a risk to themselves and/or to other family members [9]. This perception of risk is, of course, markedly divergent from the extremely small incidence of HIV conversion among health care workers [10,11]. In fact, in Canada, there have been no reported cases of HIV conversion due to occupational exposure. This suggests a need to educate the public and health care providers about the occupational risks of HIV exposure.

Confidence in medical science is also an important variable in predicting attitudes to AIDS screening and isolation. Our results show that those who are less confident in medical science are more likely to favor screening and isolation measures. Some have suggested that the inability of science to provide a cure for AIDS coupled with a general mistrust of scientific expertise and the fatal nature of AIDS tend to influence people to advocate measures that may even negate individual rights [12,13]. In the face of uncertainty, such measures may indicate a 'better safe than sorry' attitude, or alternatively, a pressure to 'do something'. Moreover, support for the particular screening and isolation measures in this study may reflect the tendency to evoke traditional public health policies that were used to arrest previous epidemics [12]. While it is often assumed that support of screening and isolation measures arises from ignorance about the efficacy and implications of screening and isolation strategies, Allard failed to confirm the relationship between misinformation about AIDS transmission and support for coercive measures such as screening and isolation [14]. Although our study did not address the knowledge level of respondents, our results suggest that one of the components of fear may be a feeling of uncertainty surrounding the present state of knowledge about AIDS. Not surprisingly, the effect of this variable seems to be partially attributed to the age of the respondent, being a health care or social service provider, and knowing someone with AIDS. However, it remains one of the most significant variables

throughout the analysis, having a strong independent effect over and above the other predictor variables.

In contrast to the above fear variables, the fear for self or someone close getting AIDS appears to be less influential in helping to explain attitudes to screening/isolation. In fact, in the final equation, fear for self or someone close has the smallest beta weight of the significant predictors. Nevertheless, the influence of this variable appears to be very stable in that its predictive power is not explained away to any significant extent by any of the other predictor variables. Somewhat surprising is the finding that age and personal exposure to others with AIDS do not influence perceived susceptibility. It appears, instead, that this variable may measure the belief that AIDS is related to certain behaviours not engaged in by the majority of respondents. In other words, respondents may view AIDS as a homosexual disease. Finally, caution must be exercised when interpreting the relative influence of the three fear variables. The fear for self or someone close getting AIDS item asks the respondent to assess his/her actual situation, whereas the concern for nurse family member refers to a hypothetical situation.

Turning now to attitude toward homosexual relationships, we find that the effect of this variable on support for screening and isolation is partially explained away by the fear variables. While this suggests that negative attitudes toward homosexuals may result, in part, from fear of contracting AIDS, attitude toward homosexual relationships consistently predicts

attitudes toward screening and isolation over and above the variance accounted for by the fear of contagion and demographic variables. More specifically, people who do not approve of homosexual relationships are more likely to favor screening and isolation policies. This supports previous research which suggests that a disapproval of homosexuality may be manifested in support of policies that identify and isolate persons with AIDS (who may be homosexuals). Of particular interest, however, is the effect this variable has on the policy of preventing children with AIDS from attending public school. Pryor et al. demonstrated similar results, suggesting that the observed negative reactions to heterosexual persons with AIDS (e.g. children) may result from a symbolic connection between infected persons and a negatively valued social group (homosexuals) [7].

The social context of participants in the study may help to further illuminate the 'association' of AIDS with homosexuality. In Alberta, 87% of all AIDS victims are homosexual men, with only 1% associated with drug misuse. There have been only 2 cases involving children [15]. Therefore, the early association of homosexuality with AIDS is reinforced by the present pattern of the disease in Alberta. This may also help to explain the low perceived vulnerability among the general population. While educational institutions have begun to establish guidelines for dealing with children with AIDS, to our knowledge, no school age children have been diagnosed with AIDS.

While attitude toward homosexual relationships has an important influence on support for screening/isolation, it explains a relatively small amount of the variance. This may be due to the single item used to assess the attitude toward homosexuality; that is, approval of homosexuals openly living together. This global item may fail to capture other aspects of attitudes toward homosexuality (eg. equality of rights, perception of normality, morality, social distancing) which could more directly influence support for coercive measures.

In sum, fear of contagion and attitude toward homosexuality each exert unique effects on attitudes toward screening and isolation. Overall, fear for a nurse family member caring for persons with AIDS and medical uncertainty assume primacy over attitude to homosexuality. In contrast, fear for self or someone close to self getting AIDS has less influence than attitude toward homosexuality and has less effect than demographic variables such as age, knowing someone with AIDS, or being a health or social services worker.

In conclusion, this research suggests areas for public health education and intervention. The screening/isolation policies identified in this study would do little to stem the spread of AIDS, and may, given the social context of participants, have undesirable consequences for those identified as having the AIDS virus. It is therefore important to educate the public about the possible ramifications of such policies. This education may be guided by an appreciation of those factors identified in this paper. In particular, it may be beneficial

to consider attitudes toward homosexual relationships and the uncertainty surrounding the scientific knowledge about AIDS. As well, the public perception of the occupational risk to health care workers would seem to be a fruitful area for exploration. Speaking on a more general level, efforts could be directed to an oft-neglected aspect of AIDS education, that of counteracting and preventing the stigmatization of those diagnosed with AIDS. Dealing with AIDS issues requires that we acknowledge the social construction of the disease, and recognize the ways that social and cultural values shape our attitudinal responses.

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